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ABSTRACT

The crisis in primary care has long been discussed and the dismal litany of statistics is now familiar. The G.P. is vanishing from the medical scene. Over one-third of the active general practitioners are now over 60. In 1970 the U.S. Congress responded to the declining availability of primary health care by passing the Family Practice Act. The intent of the bill was to subsidize the training of family physicians and paramedical physician assistants. The 3-year appropriation was to provide funds to medical schools and hospitals to defray the expense of training a new type of specialist--a family practitioner--who was to be not only far better trained than the old G.P., but would possess new skills in counseling and managing a patient in his family and community setting. This document reviews the Family Practice Act: rationale and critique, reasons for the lack of family doctors, alternative strategies for primary care, and additional recommendations. The appendix includes the Federal Family Practice Legislation. (Author/PG)

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Health Manpower Policy Discussion Paper Series

MORE FAMILY PHYSICIANS OR MORE PRIMARY CARE?
AN ANALYSIS OF THE FAMILY PRACTICE ACT (S. 3418)

by George T. Wright Jr.

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CONTENTS

I. The Decline of the Primary Physician.

II. Rationale for the Family Practice Act.

III. Reasons for the Lack of Family Doctors.

IV. A Critique of the Family Practice Act.

V. Some Additional Problems.

VI. Alternative Strategies for Primary Care.

VII. Additional Recommendations.

Appendix: Federal Family Practice Legislation.

Bibliography.

I. The Decline of the Primary Physician

Do we have a doctor shortage in the United States? If so, how long will it persist? These questions are generating increasing controversy, but all sides agree that the problem primarily concerns an apparent shortage of physicians delivering primary care. One recent survey found few deficiencies among 19 specialties, but estimated a current short-fall of 20,000 pediatricians, 10,000 specialists in internal medicine and 50,000 family physicians. This calls for at least an 80% increase in the pool of doctors in these three areas of primary care just to meet current demand.*

The crisis in primary care has long been discussed and the dismal litany of statistics is now familiar. The G.P. is vanishing from the scene. Over one-third of the active general practitioners are now over 60. Only 2% of new medical graduates are filling their empty slots. Sufficient numbers are not entering the other primary care specialties to make up the loss, and the situation is going to get far worse. Only 27% of the residencies filled in 1971 were in the area of primary care.** (See Tables I and II).

The continuously falling number of family doctors per 100,000 population has produced obvious signs of shortages: mushrooming emergency room waiting lines; long waits in the doctor's office; disappearing house

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* "Doctor Shortage: It's Narrowing Down to Primary Care," Medical Economics, 3/19/1973:105-107. Needs were estimated by optimum physician-population ratios developed by panels of experts in each of 22 fields. For a critique of this ratio methodology see Rashi Fein (1).

** Table II indicates that primary care residencies started to rapidly increase in 1969. Even at the present rate of growth, however, by 1980 there will still not be enough primary care residencies to even maintain the 1970 family physician/specialties ratio in Table I.

TABLE I

Changes in Availability of Family Physicians

	1931	1963	1967	1970
Total Physicians	156,406	261,728	294,072	310,845
Family Physician Potential	74.9%	50.8%	47.3%	41.9%
Pediatrics	0.9%	5.3%	6.0%	6.1%
Internal Medicine	2.3%	13.3%	14.4%	13.3%
General Practice	71.7%	32.1%	26.9%	22.3%
Specialties	25.1%	49.2%	52.7%	58.1%
Family Physician Potential per 100,000 Population	94.0	68.5	68.3	63.5

Notes: Covers all active physicians, federal and non-federal, except osteopaths in the United States and its possessions.

Sources: Mary D. Overbeck, "Physicians in Family Practice 1931-1967," Public Health Reports, Vol. 85, No. 6, June 1970:485-494.

A. M. A., Department of Survey Research, Center for Health Services Research Department, Distribution of Physicians in the United States 1970.

TABLE II

Primary Care Residencies 1965 - 1971

	1965			1968			1971			Average Annual Growth Rate of Filled Positions	
	Positions Filled	Vacancy Rate	% of Total Residencies	Positions Filled	Vacancy Rate	% of Total Residencies	Positions Filled	Vacancy Rate	% of Total Residencies	1965-68	1968-71
Family Practice	---	---	---	---	---	---	632	45%	---	---	a
General Practice	494	41%	---	402	55%	---	246	54%	---	-6.2%	-12.9%
Internal Medicine	5,600	13%	---	6,183	14%	---	7,869	8%	---	3.4%	9.2%
Pediatrics	2,043	15%	---	2,185	14%	---	2,844	8%	---	2.3%	10.1%
All Primary Specialties	8,137	16%	26%	8,750	18%	25%	11,591	13%	27%	2.5%	10.8%
Other Specialties	23,550	18%	74%	26,044	17%	75%	30,702	16%	73%	3.5%	6.0%

a. Family Practice Residency first offered 1970. Between 1970 and 1973 first year positions offered rose 70.7% a year, from 213 to 665.

Source: A. M. A., Council on Medical Education, Directory of Approved Internships and Residencies, Annual Editions.

call. As Table III illustrates, hospital outpatient and emergency services are now the drive engine for increasing the delivery of health care. In the meantime, since 1967 doctors have been steadily increasing their already overly long work weeks. In 1970, 50% of self-employed

TABLE III

Delivery of Health Care

	Number in 1970 (in millions)	Average Annual Rate of Growth 1967-1972
Hospital Outpatient Visits[a]	133.5	10.4%
Hospital Admissions[a]	29.3	2.8%
Doctor Office Visits[b]	1,001.3	1.7%

Notes: a. Non-federal short-term hospitals only. From American Hospital Association, 1973, AHA Guide to the Health Care Field.

b. Non-federal, non-hospital, patient-care physicians only. Includes solo and group practices. Rate of growth calculated from 1966 to 1970. Number of doctors from Department of Survey Research, American Medical Association, Distribution of Physicians in the United States, 1966 and 1970 editions. Average number of visits with non-hospitalized patients from continuing survey of physicians in Medical Economics, December 12, 1966:70-81; January 18, 1971:85-93. Adjustment for hospital visits made using 1966 data. Survey data covers self-employed physicians only. In 1972 incorporated doctors made up 18% of non-hospital physicians and saw 10% more patients than self-employed. Medical Economics, February 19, 1973: 84-90.

physicians worked more than 63 hours a week (2). Patient loads have been increasing even faster so that the amount of time per patient visit has been slowly falling. This may reflect rising physician productivity, but more likely we are seeing merely another method of rationing a scarce supply of doctors.

In 1970 the United States Congress responded to the declining availability of primary health care by passing the Family Practice Act (S. 3418; H.R. 15793). The intent of the bill was to subsidize the training of family physicians and para-medical physician assistants. The three-year appropriation ($50-, $75-, and $100 million installments) was to provide funds to medical schools and hospitals to defray the expense of training a new type of specialist--a family practitioner--who was to be not only far better trained than the old G. P., but would possess new skills in counselling and managing a patient in his family and community setting.* The pocket veto of this measure followed by a subsequent and still continuing court challenge of the veto's legality has meant that the bill has never seriously been implemented and must now be renewed in the 1974 session of Congress. The purpose of this paper is to review the Family Practice Act. What does it seek to accomplish? Is it realistic? Is it efficient? What level of spending is now required?

II. Rationale for the Family Practice Act

Given the shortage of doctors, why should we turn to a rapid expansion of family practitioners as a new specialty to fill the widening void? Six basic reasons have usually been offered by the proponents of family practice (2-6):

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*Funding for physician assistants received little attention during the 1970 hearings and will not be dealt with in this paper. For detailed description of provisions of the Family Practice Act, see Appendix.

1. Given the doctor shortage, it is far more efficient to fill the gaps by producing doctors who can meet 85% of individual health needs rather than producing teams of specialists.

2. The quality of present care is not as it should be. In a field dominated by specialists, no one looks after the individual as a whole. No one considers a health problem in relation to other illnesses, family situations or the community. At present medical specialists are trying to counsel patients in aspects of health in which they usually have no training, and often actively dislike. Surgical attention to ulcers brought on by personal and family tensions is a treatment of symptoms not the disease.

3. The present specialty structure of health delivery is costly to society and the individual. A smorgasbord of specialists are organized, paid and trained for curing crisis or periodic illness. No one has the incentive to provide continuous preventive care. Since prevention is so much cheaper for society than a cure, the present structure entails needless cost.

4. Doctors are presently poorly distributed with major deficiencies in rural areas and inner-cities. The needs of rural areas in particular cannot be met by specialists because of the low population density and lack of facilities. Only the creation of qualified generalists can solve the distribution question.

5. The present system is impersonal. Patients, particularly troubled and ill patients, need somebody they can trust and confide in. It is wrong to shuffle people from doctor to doctor according to the convenience of medical specialties. Consumer anger and distrust of the present system is largely responsible for the boom in malpractice suits. Indeed, consumer demand for continuity of care is so strong that it forces many specialists to treat conditions in their patients and family members far removed from their own specialties (2; 10/30/1967:74-80).

6. The present complex specialty structure makes access to the health care system difficult for many patients. One of the reasons for mushrooming hospital clinic visits is that confronted with a confusing array of specialists, the patient has no idea who to start with. The family physician could become the universal port of entry into medical care.

III. Reasons for the Lack of Family Doctors

These arguments have been powerful enough not only to persuade the AMA into sanctioning a new specialty, the Board of Family Practice, but to obtain from Congress an authorization subsidizing this new specialty

at a planned, continuous level of $100 million per year. Yet behind all of these arguments lies a nagging question. Why is it that in the face of a clear and growing need for primary care, organized medical education has consistently failed to turn out the doctors to meet the need? This is a vital question, for the answers can determine what type of public programs will be successful in altering the output mix of medical education. If we deal with only the symptom of a meager production of primary physicians instead of determining its cause, Congressional action to increase the supply of family doctors is likely to be unsuccessful.

There are two alternative basic explanations for the falling production of primary-care physicians:

1. The entire structure of medical education is fossilized and indeed has become increasingly so irrational that its composition of output has become severely distorted.

2. The life-time income of family practice, adjusted for the personal enjoyment and prestige of the field, simply cannot compete with the returns of specialization. Medical education does not turn out family doctors simply because, under present conditions, few students want to become family doctors.

Examining these two explanations in turn, the first holds that the combination of rapidly expanding medical knowledge and enormous public support of research has perverted medical education. Medical schools have increasingly become research mills with education emerging only as a by-product, and since research proceeds along increasingly narrow and specialized lines, the training of new MDs follows apace.* In addition, the research

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* In 1968 fully 43% of all medical school expenditure was devoted to sponsored research projects. In many of the most prestigious and largest medical schools, the proportion far exceeded 50% (7).

domination of medical schools has meant that until very recently there have been absolutely no generalists on teaching staffs, no alternative model, no alternative points of view for students. From the specialists, the students quickly learn that there is no academic "coin of the realm" in general practice with its lack of research opportunities. The lack of exposure to a generalist practice and viewpoint is particularly disastrous for the conscientious student who is completely overwhelmed by the volume of medical knowledge and becomes convinced that the only way to deliver quality care with any degree of self-confidence is to specialize in only one (and increasingly limited) area (8).

The second explanation admits all of the above but finds the problem far more complex than a simple failure of the educational process. There is some survey evidence which demonstrates that primary care physicians are the most discontented of practicing doctors. In one study, 54% of pediatricians, 36% and 32% of general practitioners and internists respectively were not particularly satisfied with their careers (2; 10/3/1966:158-162). These levels are far below the high satisfaction scores of ophthalmologists, orthopedic surgeons and the like. What are the sources of discontent? The list of complaints is well known (9; 10; 17; 18; 28; 30):

1. Overwork: absurb and irregular hours, increasing patient loads, impossibility of arranging for vacations, weekends or time off for study and conferences.

2. Low Prestige: particularly a problem for G.P.s suffering poor relations with consulting specialists and frequent struggles over hospital privileges. For internists the broad sweep of the general field is poorly recognized as a specialty by the public and is increasingly challenged as a viable specialty by elements in the medical profession.

3. Lack of Patient Confidence: patients, even in rural areas, tend to go out of their way to see specialists and come to generalists only in an emergency, such as nights and weekends when the specialist is not available.

4. Boredom and Tedium: particularly in pediatrics, doctors face an endless daily stream of minor complaints and routine procedures. Cases which are challenging tend to be increasingly referred to the specialist, robbing the practice of much of its challenge and vitality.

5. Inadequacy of Care: general practice with its heavy caseload allows physicians little time for professional growth, little time to improve his already broad but inadequate knowledge.

6. Low Income: there is fee discrimination since third parties allow specialists higher charges for similar services provided by primary M.D.s More important, third parties do not even cover many services which form the bulk of primary care work loads. Pediatricians in particular complain of low fees and inadequate income.

The last point is of particular significance. Not only does primary care in general and family practice in particular carry a considerable load of unattractive work conditions, it pays poorly in relation to many of the more favored specialties. Setting aside all the non-pecuniary benefits of specialization, one study simply looked at the two to four years of additional study in residencies as an investment by the new M.D. in order to gain income above the average G.P.s life-time earnings (11). Is this a good investment? The results for 1965 presented in Table IV suggest that for the more narrowly defined specialties, it pays well, but for the primary care specialties (pediatrics and general internal medicine) it pays not at all.

Have conditions changed much since 1965? The income data in Table V indicate that general practice has just kept up with the median income

TABLE IV

Internal Rates of Return to Specialization (1965)

Radiology	16.1%
Orthopedic Surgery	13.8%
Ophthalmology	12.4%
Anesthesiology	10.0%
General Surgery	5.2%
Obstetrics-Gynecology	4.8%
Psychiatry	3.9%
Internal Medicine	1.5%
Pediatrics	Neg.

Source: Frank Sloan, Lifetime Earnings and the Physician's Choice of Specialty, New York: Rand Corporation, 1969 (P-4068).

growth of all physicians while internists and pediatricians have fallen behind, making their specialty training an even poorer investment than in 1965.*

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*The figures for 1971 indicate a fantastic jump in incomes, particularly for internists and Ob-Gs. If this is a new trend, then primary care will become a more attractive alternative. G.P.s - $39,500; Internists - $39,250; Pediatricians - $33,750; Ob-Gyn - $45,780; Gen. Surgery - $45,330. Medical Economics, 11/20/72:134.

TABLE V

Net Income from Private Practice of Self-Employed Physicians

	1955	1965	1970	Annual Rate of Growth 1955-1965	1965-1970
General Practice	$14,817	$25,090	$36,500	6.9%	9.1%
Internal Medicine	14,350	27,730	39,250	9.3%	8.3%
Pediatrics	14,992	25,240	33,750	6.8%	6.7%
Obstetrics-Gynecology	20,000	30,520	45,780	5.3%	10.0%
General Surgery	18,975	32,510	45,330	7.1%	7.9%
All Physicians	16,017	28,960	41,880	8.1%	8.9%

Source: Continuing Survey of Physicians, Medical Economics, 4/1957: 246-279; 5/1957:115-124; 5/14/1968:62-75; 11/20/72:134.

Data covers self-employed physicians less than 65 years of age. Net income is gross income from practice net all tax-deductible professional expenses before payment of income tax. All figures are medians.

The nation therefore faces a situation in which general practice is poorly regarded by most medical opinion makers, carries substantial negtive side-effects for general practitioners themselves, and is financially unrewarding relative to most specialties. At a minimum, G.P.s are not financially rewarded for the low prestige and poor working conditions. The two specialties which do provide substantial primary care are the same two which do not remunerate the M.D. for the costs of special training; they are also the same two which rank low in career satisfaction.

The general presumption of low presitge in primary care is supported by a 1958 survey of faculty opinion in 15 medical schools. Of twelve specialties, pediatricians and G.P.s ranked seventh and tenth in prestige. A 1968 survey of a single medical complex suggested an improving G.P. immage with a ranking of six out of twelve. (32).

IV. A Critique of the Family Practice Act

The Family Practice Act of 1970 ignores much of this reality. The House and Senate testimony for the bill concentrated almost exclusively on the argument that family doctors are disappearing because ossified medical schools refuse or are unable to produce them. Indeed, the requirement that recipient training institutions will be eligible only if they establish a separate Department of Family Practice is a prime example of the strategy implicit in the bill. Using a substantial monetary bribe, the bill seeks to force medical schools and teaching hosp als to change the mix of their training effort. The goal is simply to supply family doctors. It is basically assumed that: (1) a sufficient number of medical students want to enter the new field of family practice; (2) the effective demand to employ and actually pay the new specialists at going income levels exists; and (3) the jobs will be sufficiently attractive to hold the graduates in long-term career of family medicine.

Examining these assumptions in turn, advocates of family practice have maintained that there is substantial suppressed student interest in and commitment to family practice. There is,however, little hard evidence to support this contention. Between 1950 and 1961 the proportion of senior medical students planning to enter family practice feel from 33% to 18% (12). By 1972 the figure had fallen to 12.5% (13).* Student idealism is indeed increasing. Over 40% now hope to spend some time in underserved areas, but the common fears and perceptions of a general rather

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*In their 1973 convention, the American Academy of Family Physicians claimed that 20% of seniors are choosing family practice. This still represents little improvement over the past decade.

than specialized practice undercut a strong movement to family practice. Such a career is deemed by students to have long and irregular hours, to be dominated by monotonous and uncreative work, to demand relatively low pay and undesirable locations, to prevent the doctor from keeping up with the scientific explosion and thus delivering the best care (13, 14, 15). It would be unwise to dismiss these objections as misconceptions which can be overcome by exposure to family practice.

The second assumption that the demand for new specialists in family medicine actually exists needs clarification. Family practice is a rubric covering three rather separate roles, the physician as: rural doctor, friendly counsellor, and health team quarterback. In the first role they are presented as the only feasible model for bringing quality care to underserved areas. Second, they are seen in a fuzzily defined manner as an updated G.P. who is to be the core for restructuring health delivery--the only way to put the "heart" back into medicine, to make the profession humane, offering treatment for people instead of diseases. Lastly, the family physician is seen as a new type of doctor specializing in over-all care in cross-specialty group practice. He is to be skilled in assessing patient needs, managing treatment between specialists and relating physical care to the emotional needs of the patient in his family setting. He is to tie physical and mental health together.

Most of the congressional testimony for the Family Practice Act concentrated solely on the rural doctor role. The primary interest in public subsidization of family medicine was in creating qualified physicians who could solve the poor geographic distribution of health services in the United States. This is surely a dubious justification for the bill.

Beyond the simple production of doctors, nothing is said about how we shall induce doctors to move their families into undesirable areas with low income potential, poor schools, alien neighbors, etc. The problem of underserved areas is obviously complex and in desperate need of an integrated public program to meet all facets of health care. Subsidizing the education of family doctors on the grounds of helping deprived areas is essentially unjustified unless effective policies exist for placing the new graduates where they are needed. Such policies do not yet exist.

Finally, will the practices of family physicians be so rewarding that M.D.s trained in this specialty will stay there? Currently there is evidence to suggest that despite the rigidities of specialization, there is considerable career fluidity between specialties and that the big losers are the fields of primary care. Of the 1950 and 1960 graduates of the University of Chicago Medical School 51%, of those planning to enter general practice, 33% and 22% of those planning careers in pediatrics and internal medicine have entered other specialties (16). In Canada 55% of the Queens University medical students (1949-1958) whose first career choice was family practice entered other specialized fields (19). Clearly, not only does family medicine attract a small proportion of graduating seniors, but perhaps half of these leave the field. The fact that the new family physicians will have three years of residency and that many specialty boards are increasing the flexibility of their requirements makes it that much easier for family physicians to switch to a specialty if they become disgruntled with their practices. A crucial question then becomes, will a new board-certified specialty of family practice be able to so improve upon the old G.P. that the attrition rate will drop off and

the attraction of medical students will accelerate.

At this point there is considerable debate. Clearly, the intent of the new specialty is to turn out M.D.s who are trained to expertly evaluate surgery and obstetrics, but who are not expected to routinely undertake such procedures. They are commonly pictured as the quarterback of a health team referring complex problems to specialists. This image of a doctor has been consistently attacked by both G.P.s and specialists (20,22,23). Four years of medical school and three years of grinding residence seemingly produce only a super triage officer. The concept of the specialist in non-specialization has been excoriated as a "semantic mirage" in which the doctor gives away to the more qualified specialist almost every physical or psychological case which is unusual or challenging. The seven years of training wither under a barage of vaccinations, ear infections, over-weight neurotics and aging hypochondriacs. This is powerful if somewhat overstated criticism, but it has only been vaguely answered. How professional boredom is to be circumvented remains a fundamental challenge.

The difficulties with the intrinsic rewards of family practice make even more urgent the question of financial return. The family practice specialty demands that a new M.D. give up two or three years of substantial income he could be making as a G.P. in order to join a resident program. It requires that he give up the lifetime income he could make in another specialty with the same time in residency. These are substantial costs to an individual and the obvious question is, will the income of board-certified family practitioners be high enough above G.P. incomes to make the training a worthwhile investment? If this does not occur, we are asking

new medical graduates to make a considerable sacrifice to join family practice and the numbers will be limited to only the most altruistic. We will not see the massive expansion envisioned by the advocates of family practice.

It is indeed difficult to see how the family practitioner will earn more than a G.P. First, the near universal "customary and prevailing" system of fee reimbursement by Blue Shield, Medicare and Medicaid enshrines the ability of different specialists to charge different fees for the same procedure or service. The self-reporting nature of this system allows the customary fee to be largely determined by the individual physician's and his specialty's market power. The question is, will the public be willing to pay more for an examination or vaccination by a family physician than by a G.P.? One suspects not.* An early survey of family specialists indicated absolutely zero public awareness of their new status (21). Such awareness will take a long time to develop.

The question of fee differentials, however, pales before the problem of fee structure. The family physician is seen as referring to specialists not only his most challenging cases but also the very cases which produce high fees. As one critic bluntly put it (22):

> How much bread will the family practitioner of the future earn? Not much. G.P.s don't acquire bank accounts by looking at red tonsils; they earn money by taking those tonsils out. At $5.00 per visit . . . a G.P. has to listen to 35 women moan and groan about how tired they are just to earn the $175.00 he can get by removing an appendix.

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*Family practitioners in some isolated areas might be able to raise their fees due to the lack of competition, but the usual low incomes of such areas and continual spread of third party fee control makes this an unlikely possibility.

The consequences of such a structure of family practice is vividly demonstrated in a recent study of doctors in Saskatoon, Saskatchewan. Public insurance has standardized fees for similar service across all specialties. As Table 6 shows, the family doctors in a new consumer controlled multi-specialty group received substantially less than their fellow generalists.

TABLE 6

Comparison of Family Physician Incomes
(Saskatoon, Saskatchewan; 1965)

	Family Physician In:		
	Multi-Specialty Group Practice	Newcomers to Other Urban Groups	All Urban Family Doctors
Total Income	$17,043	$22,749	$32,101
Number of Patients	1,636	1,680	1,761
Average Payment per Patient per Year	$10.42	$13.54	$18.23

Source: Samuel Wolfe and Robin F. Badgley, The Family Doctor, in The Milbank Memorial Fund Quarterly, Vol. L, No.2, Part 2, 4/1972:125.

The reason for the low income is not hard to fathom. The group practice family doctors referred away most of the potential high fee work. They did only 1/15 the major surgery, 3/5 the minor surgery and 2/5 the obstetrics that other urban family doctors undertook. They had few surgical assists and no anesthesia work. The point is clear. The stark issue facing family practice specialty is not how their incomes will be maintained at G.P. levels. Unfortunately, few proponants of family practice have faced this problem squarely (31).

The thrust of all this critique has been to raise doubts about the viability of the family practice specialty as the wave of the future. If we use public funds to subsidize their education, will we get our money's worth? There is room for substantial doubt. Certainly the more than twenty years experience of federal funding for training in psychiatry and physiatry (physical rehabilitation and therapy) offers little encouragement. By 1971 the annual federal stipend and training support for these two specialties had reached $45 million, and yet there is no evidence to indicate any great increase in their numbers as the result of public effort (24).

V. Some Additional Problems

In addition to the preceeding general critique, there are two other major problems with the Family Practice Act as it now stands: its financial arrangements and its limitation to one specialty. There is little indication of what level of results Congress expected from an annual expenditure of $100 million. One set of cost and output estimates was provided by the president of the American Academy of General Practice, Dr. Edward Kowalewski (3). His testimony proposed establishing 310 hospital residency programs and 85 medical school programs which would turn out 1,580 family practice residents a year. This output would require $300,000 start-up costs per hospital or medical school and an annual total operating cost of $9,875 million. These figures imply that it will cost $187,500 in operating costs and $4,167 in start-up costs (assuming 20-year amortization) to put one M.D. through a three-year residence program in family medicine. This is a fantastic figure, but

Kowalewski's total figures for the first three years of $51, $72.5 and $99.0 million is almost exactly what Congress authorized. Is this $200 thousand per student funding to pay for the operation of model family practice clinics or what?

The second question has much broader implications. The real shortage in the medical system is not in a new specialty to replace the vanishing and ill-trained general practitioner, it is in primary care. The Family Practice Act, however, locks us into meeting this shortage with only one of many possible types of delivery systems. It accepts as the sole answer the new American Board of Family Practice. Because of their wide sweep, specialists in internal medicine and pediatrics are commonly considered part of primary health care. Indeed, they now outnumber G.P.s. In addition, 62% of internists and 23% of pediatricians practice outside of their specialties in generalized care (2; 10/30/1967: 74-78). Why, then, are these two specialties completely ignored in this legislation?

In 1968 the boards of internal medicine and pediatrics announced a program offering dual certification with the ostensible aim of creating a new family physician. The American Academy of General Practice was infuriated and called the move "100% political," a blatant attempt to undercut the Board of Family Practice which was still struggling for certification (23). This they received in 1969, and the following year Congress enacted the $225 million Family Practice Act solely for the benefit of the new board. In effect, Congress has been called upon to arbitrate a specialty dispute within the medical profession.

VI. Alternative Strategies for Primary Care

The real problem with the Family Practice Act is that it seems to be addressing the wrong question. The problem is not the lack of family doctors, but the lack of primary health care. Simply put, other than merely creating a new breed of physician, we should also examine alternative strategies of increasing the delivery of primary care. There is a fundamental contradiction in the whole concept of the board-certified family practitioner. On one hand we have seen the decline of primary physicians largely because they undergo such arduous and expensive training that their subsequent practices, which are comparatively low in prestige, pay and medical challenge, simply don't make the career a worthwhile choice. On the other hand, the proposed solution to this dilemma is a new physician whose training is even more arduous and expensive but whose practice will continue to be dominated by the routine and will probably not be particularly lucrative in relation to other specialties.

Should we not consider a new strategy for delivering primary care, one which is built around a physician with less not more training? Would it not be possible to create an M.D. with a limited license (perhaps called a Bachelor Doctor)? These new doctors would receive three or four years of training with emphasis not on treatment so much as diagnosis. They would not be licensed to do surgery, obstetrics, anesthesia, or the like, nor would they receive specific psychiatric training. They would, however, receive extensive experience in counselling (à la social work or clinical psychology). This Bachelor Doctor would have the skills to become the "super triage officer" in multi-specialty groups, the first

contact physician of choice for large group enrollees. Although not expected to handle hospital-based medicine, he/she would fit the primary care needs of most rural areas. For the medical system as a whole, the Bachelor Doctor would be the wide-spread point of entry who would offer continuous care to the family, handling perhaps 70% of all complaints.

Such a limited license doctor could answer many of the problems with the delivery of primary care. By cutting specialty training time in half, the lower incomes of pure primary care would still be attractive. Since they would still receive medical degrees, Bachelor Doctors could still be accepted by patients as competent and qualified. For society as a whole, a Bachelor Doctor offers a hope of filling our primary care shortages with much less sacrifice in training cost and manpower than the substantial program envisioned by the advocates of family practitioners. To make this new type of doctor viable, however, training should be provided by a few large, distinct programs attached to medical schools committed to the concept.*

This proposal for a new means of deliverying basic health services is admittedly sketchy, but it illustrates the search for alternatives which must occur if we are to meet society's demand for care at a reasonable cost. An alternate type of health manpower with less training instead of more is actually provided for in the Family Practice Act--the physician assistant. The creation of a middle level professional has the potential

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*There have been a number of proposals for a new-type of physician who would concentrate on primary care, receive less education, and have his/her areas of competence carefully restricted. Variously called a doctor ofprimary medicine or a medical practitioner, their length of grades into proposals for physician assistants. See footnote 29 for a recent review of proposals.

for greatly increasing the doctor's productivity. By taking over a large amount of the routine processing and examination of the patient, the physician assistant can not only significantly boost the patient load of primary physicians, he will simultaneously increase their incomes through volume and reduce much of the routine drudgery which is the complaint of so many M.D.s. Indeed, the physician assistant may be necessary to make a family physician's income and subjective job fulfillment a viable alternative to other specialties. Unfortunately, the concept of the physician assistant is experimental and involves a host of policy questions which must await another paper. At a minimum, before more public monies are devoted to educating physicians assistants, the following two steps should be taken:

1. We are now facing a jumble of new professions--physician assistants, nurse practitioners, nurse clinicians, midwives, etc. These different job titles tend to have sealed training programs so that the years spent toward becoming R.N. do not count toward becoming a physician assistant. Before subsidizing any of these programs we should determine what different roles they will play and why the separate titles and rigid compartmentalized training programs are necessary.

2. If the physician assistant is to really work with primary doctors, he should be trained in a setting similar to that of M.D. training. Funding small programs scattered over a wide variety of junior colleges is unlikely to produce high or uniform quality. Public support should, therefore, be limited to schools and hospitals which are actively training family physicians or similar primary care M.D.s.

Even if we decide that society needs many more family practitioners, the training of more physician assistants/nurse practitioners is part of a broad approach which has been ignored by the Family Practice Act. The bill assumes that the answer to family physician shortage is to subsidize their training. The thrust of this paper, however, has been to argue that

this limited strategy, by itself, is not likely to produce the desired results. Consideration should be given to public programs which will not only increase the number of doctors, but boost the relative status, working conditions and income of primary care physicians. Possibilities in this field include: support for sabbatical leaves and research time for primary physicians; increased support for short-training courses on the use of physician assistants and nurse practitioners including subsidized trial periods for new para-medical personnel; tax concessions for primary physicians; allowing medicare and medicaid fees for primary care to rise while continuing the freeze on other charges; increasing the primary services which are covered by third parties.

Equally important is an overall approach to the problem of geographic maldistribution and the question of rural health services. These challenges are so complex that they cannot be dealth with in the scope of this discussion and will hopefully be covered in a subsequent paper.

VII. Additional Recommendations

Beyond these broader alternatives to the approach of the Family Practice Act, the general points raised in the preceeding analysis suggest some concrete recommendations for reshaping any subsequent renewal of this legislation.

1. The limitation of all funds to only separate departments of family medicine should be dropped and coverage extended to a broader definition of primary care. There are still substantial shortages in pediatrics and internal medicine. As indicated back in Table II, these two specialties are expanding very rapidly and offer much more hope of eliminating primary care shortages than a brand new field by itself. In particular,

proposals for establishing specialized three-year residencies in internal medicine for producing adult primary care physicians should be given serious attention. At the same time, subspecialties such as pediatric cardiology should be excluded from funding and requirements that mandate (a) substantive work in counselling and emotional needs of patients and (b) extensive outpatient experience should be added.* Simply put, the problem of primary care is too important to limit support to one highly experimental specialty. This approach has already been adopted by Congress in Section 768 of the Comprehensive Health Manpower Training Act of 1971 (PL92-157). The two-year authorization for $22.5 million was for postgraduate training in primary care: family practice, internal medicine and pediatrics. Subsequent recommendations are phrased in terms of "family practice." They should also be considered in terms of "primary care."

2. The recipients of government aid and the uses to which it is to be put should be more carefully defined. There should be separate funding for graduate residence programs and undergraduate departments. The average resident stipend is now about $11,060 which breaks down by year as follows:

TABLE 7

Stipends of Residents 1972-1973

Year	Mean[a]	Median[b]
1st Year	$10,398	$10,400
2nd Year	11,006	10,750
3rd Year	11,592	12,130

Sources: a. "Datagram," Journal of Medical Education, Vol. 47, No. 11, 11/72:917.

b. Hospital Physician, Annual Survey.

This means that the Federal government could provide full stipend support for all residents in the primary-care fields

*This suggestion should prove highly controversial as a federal intervention into the purview of specialty boards. These may have to be added as administrative "guidelines" for priority consideration.

of family practice, general practice, internal medicine and pediatrics for under $160 million, a figure that compares favorably with the $100 million annual subsidy in the Family Practice Act. A study of family practice residence programs in seven Indiana hospitals indicates an average gross cost of $30,000 per resident. Subtracting the revenues from model clinics brings the cost down to the range of $20,000 (25). The full cost of running three-year programs graduating 1,000 family practitioners a year could be underwritten with a $60 million subsidy. Stipend support should follow the principles of "Institutional Grants" in the 1968 Health Manpower Act--a basic capitation plus incentive for increases in program size.

3. In all programs for stipend support and development grants, care must be taken to integrate federal efforts with state spending in the area. Since 1967 Indiana has been spending significant sums for resident stipend support. Iowa has just passed a $925 thousand program to support family practice residencies. Minnesota provides similar residents $15,000 annual capitation allotment. Michigan is considering an $8 million proposal to support graduate medical training. Overall, family practice is now being taught in over 160 residence programs and 60 independent departments in medical schools, and all of these are run without massive federal support. Federal aid should not choke off local participation in the funding of primary care programs. All grants should be of a matching character and could, in many cases, be a candidate for local administration-revenue sharing with strings. This is particularly important in the case of statewide supervision of residence programs (e.g. the proposed Michigan SHOTS--Statewide House Officer Training System).

4. The authority for construction grants should be severely restricted and perhaps even eliminated from the bill. Present residence programs are too small to justify construction. Certainly the experience of the seven family practice programs in Indiana indicate little need for construction or elaborate new equipment. Capital costs ran only $20 to $30 thousand a program (25.) Grants for new buildings are the easiest of all monies to spend and are treated as a free good by local institutions. Construction grants tend to purchase lots of construction and little training. There is, however, probably a need for some schools and hospitals to develop expanded outpatient services and satellite clinics before they can undertake meaningful family practice programs. Such needs should be taken care of, if at all, in separate legislation for health care facilities.

5. Special attention should be given to HMOs. The family physician, as a new breed of specialist ideally suited for large group practice, can be well trained in HMOs. These organizations, however, commonly involve no third parties which can absorb training costs, and thus they have been reluctant to take on many residents. They may thus require a higher level of capitation.

6. At present, family practice residence programs average only six fellows per program. The temptation to try and cure shortages in primary care personnel by scattering programs over a myriad of small hospitals should be resisted. Family practice is still highly experimental. Indeed, the Millis Report in calling for a whole new curriculum to be added to the standard clinical specialties admitted that, "It is difficult to define this body of knowledge, for it is not yet adequately developed." (4) One cannot expect a small community hospital to develop this new curriculum. Such family practice residencies would probably become warmed-over G.P. residencies or souped-up rotating internships. Limits on program size, hospital size and affiliation should be established.

7. The language of the Family Practice Act is in terms of "medical schools." Support for schools of osteopathy scattered in other manpower legislation should be reviewed and consolidated in connection with primary care. Osteopaths concentrate on primary care, particularly in rural areas.

8. A traditional prescription for the lack of primary physicians, particularly in underserved areas has been to recruit rural and minority students for medical school. A recent review of this policy, however, concludes that it has not been effective (26). We should consider, therefore, substantially increasing the enrollment of women who tend to concentrate in primary care, most strikingly in pediatrics at a rate three times that of male M.D.s (27).

9. Subsequent congressional hearings on renewal of the Family Practice Act should include testimony from past critics of the family practice specialty and representatives of the boards of other primary care specialties.

APPENDIX

Federal Family Practice Legislation

1. Family Practice Act of 1970 (S. 3418; H.R. 15793)

The Family Practice Act was passed by both houses of Congress in December 1970, but was never signed. The legality of the use of a pocket veto over the Christmas break was challenged in the courts, and in August 1973, the Family Practice Act was declared to have become law. The case is now on appeal to the Supreme Court. The Act is in the form of an amendment to Title VII of the Public Health Service Act. It provided a five-year authorization for fiscal years 1971 to 1973 of $50--, $75-- and $100 million with a stated intention for continuing authorization at the $100 million level for fiscal years 1974 and 1975. All funds were to be dispersed as grants which were to be used as follows:

1. Grants to medical schools for undergraduate programs in family practice. The major restriction was that only schools with "separate and distinct" departments of family practice were eligible for support. The grants could be used for funding:

   a. Construction of facilities "appropriate to carry out a program of training." These could include expansion of school or separate outpatient facilities.

   b. Training programs for teaching staff and departmental heads of family practice programs.

   c. Operating costs of departments of family medicine.

2. Grants to hospitals with approved residency and intern programs in family practice. These grants could be used for funding:

   a. Construction of "appropriate" facilities either as part of the hospital or separate outpatient facility.

   b. Operating costs of training programs in family medicine. These include not only interns and residents, but medical students and continuing education for practicing physicians.

c. Fellowships and stipends for interns, residents and "other medical personnel" participating in training programs.

3. Grants to medical schools and participating hospitals with programs for paramedical personnel in the field of family medicine. The grants were primarily intended to cover operating costs.

For advice and assistance in administrating the program and establishing policy guidelines, the Act provided for an Advisory Council on Family Medicine with twelve members: one-third practicing family physicians, one-third from programs teaching family medicine and one-third from the general public.

II. Comprehensive Health Manpower Training Act of 1971 (PL 92-157)

The major elements of the Family Practice Act are scattered in various sections in this 1971 legislation.

1. Grants to schools of medicine and osteopathy are specifically authorized under the Special Project Grants (Sec. 772, (a), (1)). This authority is aimed not at operating costs but funding the establishment and expansion of programs. Although the three-year authorization runs over $300 million, programs in family medicine are buried among a host of other fundable programs.

2. Grants to hospitals with approved residency programs in family practice (Sec. 767). Authority is provided to "plan, develop, operate, or participate in" training programs, but there is no specific construction authority. The Act contains a three-year authorization for fiscal years 1972 through 1974 of $25--, $35--, and $40 million. Only $5 million was appropriated in fiscal year 1972.

3. Grants to hospitals and schools of medicine, osteopathy or dentistry with graduate training programs in primary care (Sec. 768). Authority was granted to provide a capitation of $3,000 for each physician or dentist in graduate training programs to defray education costs. The definition of "primary care" was not specified in the legislation, but was intended to cover areas other than family practice specialty. The two-year authorization for fiscal years 1973 and 1974 was passed at $7.5 and $15 million.

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